Defective eosinophil chemotaxis to eotaxin in a patient with chronic lower baseline CD4⁺ T-lymphocytes and elevated CD8⁺ T cells

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Background: Idiopathic selective CD4⁺ lower baseline cell count and an increase in CD8⁺ cells is an unusual immune defect. Whether this is a true variant of idiopathic CD4⁺ T lymphocytopenia (ICL) or a sequelae to recurrent infections is not clear.

Objectives: The primary objective of this study was to investigate the expression and function of the cc-chemokine receptor CCR3 in eosinophils from a female patient with this disorder. A secondary objective was to study the in vitro ability of different cytokines to modulate the reversed CD4⁺:CD8⁺ ratio in this syndrome.

Participants: A female patient suffering cellular immune defect with chronic lower baseline CD4⁺ counts with persistent increase in CD8⁺ cells, and positive skin test and radioallergosorbent test to pollens. Seven volunteers served as controls: five healthy subjects and two allergic volunteers (one asthmatic and one rhinitic).

Results: The patient’s eosinophils had defective chemotaxis, shape changes, and F-actin reorganization against eotaxin, when compared to the controls. CCR3 surface and total expression was highest in allergic subjects and least in the patient with cellular immune defect. Culture of eosinophils with interleukin-7 (IL-7), but not IL-2 for 24 hours resulted in increased expression of CCR3 in both the patient and controls as evidenced by fluorescence-activated cell scanning (FACS) analysis. Confocal microscopy demonstrated cytoskeletal changes and F-actin reorganization of the patient’s eosinophils only after treatment with IL-7. Culture of the patient’s lymphocytes with IL-2, IL-7, IL-10, IL-17, IL-15, or phytohemagglutinin increased the number of the patient’s CD4⁺-expressing lymphocytes as measured by FACS analysis. The potency of correcting the CD4⁺:CD8⁺ ratio from a baseline of 0.5 was highest with IL-10, followed by IL-15, while the rest of the cytokines had a similar ratio, being 0.8, 0.7, and 0.6, respectively.

Conclusions: Taken collectively, our preliminary results may indicate a novel role for IL-7 in enhancing the CCR3 expression and function in patients of this syndrome and highlights the novel role of IL-10 in inducing a significant increase in CD4⁺-expressing lymphocytes from the patient when compared to controls.

Keywords: eosinophil, defective chemotaxis, CCR3, eotaxin, CD4⁺:CD8⁺ Ratio, IL-7, IL-10

Introduction
Patients with idiopathic chronic selective lower baseline CD4⁺ cell count with reversed CD4⁺:CD8⁺ ratio is underreported in the literature. Whether these patients represent a variant of idiopathic CD4⁺ T lymphocytopenia (ICL)¹ is not clear.

ICL syndrome is characterized by selective CD4⁺ cells depletion but without the presence of a recognizable cause of immunodeficiency. Negative tests for HIV1 and
HIV2, CD4⁺ cell count less than 300 mm⁻³ of blood, or a total
CD4⁺ cell number less than 20% of total lymphocytes count,
on two different occasions with at least a six-week interval,
are essential for ICL diagnosis. Nonetheless, the clinical
spectrum of ICL may range from incidental asymptomatic
laboratory findings to severe cellular immune responses and
serious infections.² ³

In a recent cohort study⁶ describing the clinical course
of 39 patients with ICL with follow up for a median of
49.5 months, 32 patients remained with CD4⁺ counts
less than 300 mm⁻³ and the counts normalized in seven
patients after an average of 31 months. In addition to the
CD4⁺ lymphocytopenia, several patients also have CD8⁺
lymphocytopenia or an increased CD8⁺ cell count while
low B or NK cell counts have also been reported in other
studies.² ³ ⁴ ⁵ ⁷

Localized inflammation associated with the recruitment
of lymphocytes and eosinophils play an important role in the
host’s cellular immune response to infections. The presence
of these inflammatory cells participates in the resolution
of various infections. Patients with acquired immunodefi-
ency syndrome (AIDS) may have defective lymphocyte
chemotaxis⁶ and an earlier report demonstrated a defective
p56Lck tyrosine kinase activity in a patient with ICL with
severe depletion of CD4⁺ cells and increase in CD8⁺ cells.⁷
These studies also demonstrate the defective function of the
remaining CD4⁺ cells.

A female atopic patient presented to our clinic with
recurrent otolaryngologic infections and a diagnosis of
airway allergy to pollens confirmed by skin test and radioal-
largosorbent test (RAST). The patient had suffered several
mixed infections in the past 10 years including severe
viral, bacterial, and fungal microorganisms for which
she received one antiviral protocol elsewhere (Cartolus,
Lymphomyosot, taurine, vitamin C, iron tablets, Radinorm,
and selenothionine) that increased her CD4⁺ with improve-
ment of the CD4⁺:CD8⁺ ratio to 1.3 temporarily, but her
general condition worsened and the antiviral regimen had
to be stopped. This may indicate that the problem is at the
level of the function of the cells and not the low number only.
Otherwise she was treated symptomatically with antibiot-
ics and supportive measures when needed, and she never
received specific immunotherapy. Her CD4⁺ cells remained
at 28%–30% of total lymphocytes with lower border CD19⁺
B cells but no hypogammaglobulinemia. Her persistent
elevation of CD8⁺ cell count (55%–60%) resulted in chronic
CD4⁺:CD8⁺ ratio fluctuating between 0.4–0.6 over several
years. No other abnormalities of the subtypes of lymphocytes
or obvious cause of immunodeficiency could be detected
(Table 1). Clinical examination in several occasions showed
rhinopharyngitis atypical of allergy with occasional oral
candidiasis. Nasal biopsy showed nonspecific inflammation
with absence of eosinophils and more CD8 than CD4 in
the biopsy tissue, which is atypical of an allergy profile.
It was our hypothesis that patients with idiopathic stable
lower baseline CD4 cell count may be a variant of ICL and
may also exhibit defective inflammatory cellular function.
One important chemokine family involved in allergic and
nonallergic inflammation is the cc-chemokine involved in
calling both eosinophils and T⁺ T-lymphocytes. Eotaxin is
a classical cc-chemokine that signals through CCR3 recep-
tor expressed largely by eosinophils and to a lesser extent
in lymphocytes.⁹ ¹⁰ Recently Rzepecka and colleagues¹¹
reported that helminthic infection in a murine model of
allergic asthma resulted in reduction in the total number and
percentage of lung eosinophils that coincided with decreased
levels of eotaxin in bronchoalveolar lavage fluid (BALF),
lower expression of the CCR3 receptor on eosinophils, and
impaired chemotaxis of these cells toward eotaxin. Accord-
ingly and after obtaining the consent from all participants of
the current study, we studied the chemotaxis of eosinophils
from this patient and compared it to the normal immunocom-
petent volunteers. Several cytokines related to lymphocytes
proliferation and activation was tested to see their ability to
modify the reversed CD4⁺:CD8⁺ ratio.

Table 1 Phenotypic and functional studies of the patient’s
peripheral blood mononuclear cells

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<td>29</td>
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<td>D3⁻/CD16⁺/CD56⁺</td>
<td>6</td>
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Materials and methods

Reagents

The following reagents were used: eotaxin (R&D Systems, Minneapolis, MN, USA), ammonium chloride solution (Acros Organics, Morris Plains, NJ, USA), and Percoll separating solution with a density of 1.124 g/ml (Biochrom AG, Berlin, Germany). CD16 and CD3 MicroBeads were purchased from Miltenyi Biotec (Bergisch Gladbach, Germany). Isotypes CCR3 and CCR3-PE were purchased from R&D Systems. CD3-Pacific blue, CD4-FITC, and CD8-PE were purchased from BD Biosciences (Franklin Lakes, NJ, USA). Phosphate-buffered saline (PBS) and Hank’s buffered salt solution (HBSS) with Ca\(^{2+}\) was purchased from Lonza (Verviers, Belgium). Interleukin-2 (IL-2), IL-10, IL-15, and IL-17 were purchased from R&D Systems. IL-7 was purchased from Peptide EC, Ltd (London, UK). Diff-Quick was purchased from Baxter Scientific (Miami, FL, USA).

Cell preparation

Eosinophils and lymphocytes were purified by Percoll solution separation from the patient with cellular immune defects and chronic lower baseline counts of CD4\(^+\) cells. Seven volunteers served as controls. Two of them were allergic. One was mild asthmatic not taking inhaled corticoids and the other was rhinitic not on allergy medication. Briefly, 60 ml of heparin-anticoagulated peripheral blood were obtained by venipuncture. The blood was diluted with PBS containing 2% fetal calf serum (FCS) in the ratio of 1:1. The Percoll solution at concentration of 60% was then placed carefully in the bottom of the tube by a pipette. After centrifugation for 30 minutes at 200°C–5% CO\(_2\) and 90% lymphocytes) were washed twice with PBS and conserved in Prolong Gold Antifade with DAPI (Invitrogen Molecular probes; Eugene, OR, USA) for 30 minutes in the dark, washed twice with PBS and conserved in Prolong Gold Antifade with DAPI (Invitrogen Molecular probes; Eugene, OR, USA) and analyzed for cytometry. (TCS SP2; Leica, Solms, Germany).

Cell culture

Eosinophils or PBMC (1 × 10\(^6\) cells) were incubated at 37 °C–5% CO\(_2\) with 1 ml RPMI-1640 supplemented with 100 U penicillin/ml and 100 µg streptomycin/ml (Lonza, Verviers, Belgium), 10% of inactivated fetal calf serum (Lonza) in 24-well plate (BD biosciences). Cells were stimulated with 10 µg/ml phytohemagglutinin (PHA; Biochrom AG, Berlin, Germany) or with IL-2 (1 ng/ml), or IL-7, IL-10, IL-15, IL-17 (15 ng/ml). After 24 hours of eosinophils culture or 120 hours of PBMC culture, eosinophils and nonadherent cells of PBMC culture (>90% lymphocytes) were washed twice with PBS containing 0.2% bovine serum albumin (Sigma Aldrich, St Louis, MO, USA) and analyzed for cytometry.

Fluorescence-activated cell scanning analysis

CCR3 expression on eosinophils and CD4 and CD8 expression on lymphocytes (CD3\(^+\) cells) were analyzed by FACS (FACS CANTO II; BD Systems) as reported previously. Briefly, stimulated or unstimulated cells were fixed with 4% paraformaldehyde in the presence (total expression) and permeabilized with 0.1% Triton X-100, for another 30 minutes. The cells were then stained with Alexa Fluor 488-Phalloidin diluted 40× (Invitrogen Molecular probes; Eugene, OR, USA) for 30 minutes in the dark, washed twice with PBS and conserved in Prolong Gold Antifade with DAPI (Invitrogen Molecular probes) and analyzed by confocal microscopy (TCS SP2; Leica, Solms, Germany).

Actin reorganization assessment with phalloidin-FITC and cytoskeletal changes

Thirty microliters of cell suspensions at a concentration of 10\(^6\) cells/ml were placed in 1 µ-slide VI coated (collagen IV) cell microscopy chamber (ibidi Integrated BioDiagnostics, Munich, Germany) and left to adhere for 30 minutes. Stimulation with either buffer only or eotaxin 100 ng/ml were then performed for 15 minutes. After two washes with PBS, the cells were fixed in 4% formaldehyde for 20 minutes and permeabilized with 0.1% Triton X-100, for another 30 minutes. The cells were then stained with Alexa Fluor 488-Phalloidin diluted 40× (Invitrogen Molecular probes; Eugene, OR, USA) for 30 minutes in the dark, washed twice with PBS and conserved in Prolong Gold Antifade with DAPI (Invitrogen Molecular probes) and analyzed by confocal microscopy (TCS SP2; Leica, Solms, Germany).

Chemotaxis assay

Chemotaxis assays were performed in triplicate (and in six wells from the patient) in a 48-well microchemotaxis Boyden chamber incubated in 5% CO\(_2\) at 37 °C for 90 min. Aliquots of 29 µl of the chemotactic agent eotaxin were placed in the lower wells and 50 µl of eosinophil suspension (10\(^6\) cells/ml) were placed in the upper wells. The two chambers were separated by a polycarbonate membranes with pore size 5.0 µm polyvinyl pyrrolidone free filter (Nuclepore, Whatman, Middlesex, UK). The controls consisted of a solution of HBSS with Ca\(^{2+}\) (pH 7.4). The filters were fixed in methanol and stained with Diff-Quick. Migrated cells adherent to the lower surface were counted in five high-power fields per well under a light microscope (5 hpf; × 400).

Defective eosinophil chemotaxis to eotaxin
or the absence (surface expression) of 0.1% saponin (Sigma Aldrich) for 15 minutes. The cells were then washed and incubated with the corresponding antibody for 60 minutes in ice. After two additional washes, cells were conserved in paraformaldehyde 1% and then analyzed for their fluorescence intensity.

**Results and discussion**

Eosinophils chemotaxis against eotaxin

Eotaxin chemoattracts eosinophil in Boyden chambers at concentrations ranging from 50 ng/ml to 500 ng/ml with optimal activity at 100 ng/ml.\(^1\)\(^,\)\(^2\) Figure 1A, shows that eosinophils from the patient with idiopathic low baseline CD4\(^+\) lymphocytopenia did not show chemotactic function to the optimal dose of eotaxin, while cells from five control healthy subjects demonstrated a significant chemotactic effect. The patient's eosinophils showed similar chemotactic response to eotaxin concentrations at 50 ng/ml and 500 ng/ml (data not shown). Cell migration following exposure to chemoattractants is preceded by many processes, including cytoskeletal reorganisation and cell shape changes. Rapid and reversible polymerisation of globular monomeric actin into filamentous polymeric actin (F-actin) initiates shape changes. Therefore we

![Figure 1A](image)

**Figure 1 A** Eosinophilotactic activity of eotaxin. Results are number of eosinophils per five selected high-power fields (5 hpf; ×400) ± SEM of five independent experiments performed in triplicate from five healthy subjects. Patient results are the number of eosinophils per 5 hpf (×400) ± SEM of three independent experiments performed in six wells from the same patient (n = 1). Statistical analysis was performed by paired t-test. **B** Confocal microscopy images of eosinophil cytoskeletal changes and F-actin (green color) reorganization from (i) healthy subject representative of the five healthy subjects and (ii) the single patient. Stimulation is with eotaxin 100 ng/ml. Images are from one representative of 3–6 independent experiments which all show similar images.
performed further experiments to check these cellular events. Interestingly, as demonstrated in Figure 1B, cells adherent to the collagen type 4-coated slides from control healthy subjects responded quickly to eotaxin stimulation by shape changes and F-actin reorganization while the patient’s cells did not respond either by changing their shape nor reorganizing the intracellular F-actin.

CCR3, the eotaxin receptor, is the major chemokine receptor expressed on eosinophils but also a subpopulation of Th2 lymphocytes.\textsuperscript{16–19} CCR3 has been shown to be upregulated on monocytes and monocytoid U937 cells by interferons \textit{in vitro}.\textsuperscript{20} The only cells that consistently accumulate following eotaxin administration \textit{in vivo} are myeloid cells.\textsuperscript{21} The lack of the patient’s eosinophils to respond to eotaxin may indicate that the patient’s cells either express suboptimal CCR3 receptor or the receptor does not function by transmitting the signal transduction. We next explored this possibility in the following FACS analysis.

Surface and total CCR3 expression on eosinophils

As shown in Table 2 all studied subjects including the patient expressed the CCR3 surface receptor. However, the total expression was much higher in the control subjects than the patient and highest in the allergic individuals. After 24 hours culture in buffer medium only, 2.3% of the patient’s eosinophils expressed surface CCR3 and 74.7% had total expression. However, in the control subject the surface expression was 5.1% and the total was 93.3% while in the asthmatic subject the CCR3 surface expression was 11.8% and total expression was 94.7%. These results indicate that our studied patient actually had suboptimal expression of total CCR3. In the site of allergic inflammation there is a pool of cytokines that prime and activate eosinophils. This may explain the increased expression of the surface receptor in allergic individuals.

<table>
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<th>CCR3</th>
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<th>Healthy subject</th>
<th>Asthmatic subject</th>
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<tr>
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<td></td>
<td>Total</td>
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<td>1226</td>
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<td></td>
<td>Total</td>
<td>93.3%</td>
<td>94.7%</td>
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These results indicate that our studied patient actually had suboptimal expression of total CCR3. In the site of allergic inflammation there is a pool of cytokines that prime and activate eosinophils. This may explain the increased expression of the surface receptor in allergic individuals.

Patients with CD4 depletion due to ICL have been shown to respond well to IL-2 therapy.\textsuperscript{22–25} Few articles also demonstrated a positive response of lymphocytes to IL-7 therapy.\textsuperscript{26–27} Next we tested the ability of both IL-2 and IL-7 to induce the expression and/or function of CCR3 receptor on patient’s eosinophils. Culture of the patient’s eosinophils for 24 hours with IL-7 did modify both the total and surface expression while IL-2 increased only the total expression (Table 2). Coculture of both IL-2 and IL-7 increased the total CCR3 expression (Table 2). Only IL-7 enhanced the function of CCR3 as judged by confocal images for cytoskeletal changes and F-actin reorganization (Figure 2). Intriguingly, IL-7 also enhanced the surface expression of CCR3 in control subjects and demonstrated a potent effect in upregulating both the surface and the total expression of CCR3 in eosinophils from asthmatic and allergic rhinitis subjects (Table 2). Neither IL-2 alone nor IL-2 and IL-7 together modified the CCR3 surface or total expression in controls (Table 2). Taken collectively, this may indicate a defect of the cytokine regulating the expression of total CCR3 receptor in this patient’s cells or a bone marrow derived defect.\textsuperscript{28} Further, the Dynamics of CCR3 internalization following eotaxin stimulation on human eosinophils highlights the importance of the intracellular CCR3 receptors expression.\textsuperscript{29}

Lymphocytes modification of CD4:CD8 ratio \textit{in vitro} by different cytokines

Finally, we tested the ability of hemopoietic cytokines to modify the reversed CD4:CD8 ratio \textit{in vitro}. Studied cytokines included IL-10, IL-15, IL-17 in addition to IL-2 and IL-7. We also included PHA, a plant derivative that is known for its strong \textit{in vitro} mitogenic effect on lymphocytes. Results summarized in Table 3 indicate that all tested cytokines and HPA did actually increase the percentage of the patient’s cells expressing CD4, however, IL-10 and IL-15 were the most effective in correcting the CD4:CD8 ratio to 0.8 and 0.7, respectively. Nonetheless, IL-10 and IL-15 also enhanced significantly lymphocytes co-expressing both receptors (CD4+CD8\textsuperscript{*}). Interestingly, lymphocytes from the control and allergic patients did not show similar kinetics of lymphocytes to IL-10, however IL-15 also increased the CD4 and the co-expression of CD4+CD8\textsuperscript{*} in the control subject much higher than

Table 2 CCR3 surface and total mean fluorescence from eosinophils. Results are of three subjects representative of seven subjects. Results from the patient represent the mean values of two independent experiments. Similar results to the healthy subjects were obtained from another four controls. Similar results to the asthmatic subject were obtained from the allergic rhinitis patient.
of the allergic patients. Taken collectively, our results indicate that IL-15 is the only tested cytokine that increased the CD4:CD8 ratio in both the patient and the control, while IL-10 showed a novel and specific improvement in the CD4:CD8 ratio in the patient only. Of note PHA increased significantly both CD4 and CD8 cells as well as the cells expressing both receptors (CD4^+CD8^+), therefore it did not correct the ratio significantly. PHA also increased the CD8 cells in controls and this was much higher in asthmatic than the control. This resulted actually in reduction of the CD4:CD8 ratio in controls.

The most important infective cause of CD4^+ lymphocytopenia nowadays is human immunodeficiency virus (HIV) infection. However, other pathogenic viral, bacterial and fungal diseases may also depress CD4 cell counts but without reversed CD4^+ :CD8^+ ratio. Acute cytomegalovirus (CMV) infection can cause similar reversed CD4:CD8 ratio as in our studied patient. Although one of the severe infections this patient had was CMV seven years prior, usually CMV infection induced deranged lymphocytes counts normalizes after resolution of the infection with no differences in the counts between CMV seropositive and CMV seronegative persons. It is possible that this patient actually fulfilled the criterion of ICL prior to the first time the T-lymphocytes subsets were checked, and that her counts improved but never normalized. The possibility that this could be a distinct variant of ICL syndrome that present from the start with lower baseline CD4 counts and increased CD8 counts resulting in chronic reversed CD4:CD8 ratio should not be excluded. Another possibility of this chronic reversed ratio and the defective of eosinophil migration to eotaxin is the recurrent mixed infections. Infection down-regulated the immune response as production of Th1 (IFN-γ), Th2 (IL-4, IL-5), and Treg (IL-10)-related cytokines as well as IL-6 and tumor necrosis-α was diminished upon nematode infection and resulted in defective eosinophil chemotaxis in a murine model.

In conclusion, we provide the first evidence of defective eosinophil chemotaxis to eotaxin in a patient with what looks like a variant of ICL. Eosinophils treatment with IL-7 increased eotaxin receptor and eosinophil cellular response to eotaxin. To our best knowledge this study provides the first evidence that show in vitro activity of IL-10 in correcting the reversed CD4:CD8 ratio in patients with ICL similar syndromes. Nonetheless, it is difficult to perform a statistical analysis of our preliminary but significant findings due to the low number of studied subjects. Further studies are required with a larger number of patients to obtain a reliable statistical analysis and to further characterize the immunoregulatory role of these cytokines in this cellular immune defective syndrome.

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References


